



The Whitaker PRTF
1003 12th Street
Butner, NC 27509-1626

Beverly Perdue
Governor

Lanier Cansler
Secretary

Jeff Lenker
Director

Phone: (919)575-7927 General Fax: (919)575-7895 Confidential Fax: (919)575-7489

Dear Stakeholder,

In order for Whitaker PRTF to consider a referral, screening and prioritization of the applicant must take place at the LME level. The Secure Residential Packet attached to this letter must be completed and submitted to the local Community Collaborative for review.

Referral packets should be completed by the Community Support Provider, along with the Child and Family Teams, and reviewed by the Community Collaborative. A decision should be made with regards to the appropriateness of the referral. The child should be prioritized within the context of other referrals from the LME. The Chairperson of the Collaborative and the LME Director (or the Director's designee) **must** sign in the appropriate space at the bottom of the page for the referral to be considered. The completed referral packet should then be sent directly to Whitaker PRTF.

The referral authorization below **must** be completed and **mandatory** information provided for an application to be processed. In order for a child to remain prioritized on the list, bi-monthly updates from the LME **must** be sent to Whitaker PRTF. The form for this update is located on the last page of this packet. Updates should be faxed to 919-575-7489.

If you have questions, please contact Whitaker PRTF at 919-575-7927 (dial 0 for the operator) with any questions. You will be connected with someone who can help.

Thank you,
Ray Newnam, Ph.D.
Senior Psychologist, Whitaker PRTF
Ray.Newnam@dhhs.nc.gov
(919) 575-7105

Authorization of Referral

Name of LME: _____

Approved by Director or Designee: _____

DATE

This referral has been reviewed and approved by:

Community Collaborative Chairperson/Child and Family Coordinator/LME Director

Date

Our Program has _____ number of children referred. This child is prioritized at number _____ on the list (#1=top priority).

IDENTIFYING INFORMATION

Name: _____ Date of Birth: ____/____/____
Sex: ☐ Male ☐ Female Height: _____ Weight: _____ County of Residence: _____
Referring LME: _____
Referring Case Support Provider: _____
Phone/Fax: _____
Funding Source(s): ☐ Medicaid ☐ Private Insurance _____
Name and ID # of Private Insurance _____

CURRENT STATUS

Custody: ☐ DSS ☐ Parent(s) ☐ Other Family Member(s). Is the resident adopted? ☐ Yes ☐ No
Legal Guardian(s): _____
Address: _____

Phone: _____
Applicant's Current Placement: _____
Address: _____

Phone: _____

DEMOGRAPHIC INFORMATION AND PERSONAL HISTORY

Does this child have a family permanently committed to him/her? Yes ☐ No ☐
If "yes", how will this child's family be involved in treatment during placement? If "no", who will represent this child in the role of surrogate parent? _____

Family: (age, occupation, health, education, location, status of relations with child)
☐ biological ☐ adoptive
Mother: _____

Father: _____

Siblings: _____
_____ ☐ None
Involved Extended Family / Step-parents / Grandparents / Foster Parents: _____

Significant Developmental History: ☐None Known ☐Yes, explain: _____

History of Loss / Trauma, Abuse &/or Neglect: ☐No ☐Yes, explain below ☐Physical ☐Sexual

Family History of Mental Illness / Substance Abuse: ☐No ☐Yes, describe: _____

DIAGNOSTIC INFORMATION

Most Recent DSM-IV Diagnoses/Date of Diagnosis

I. _____

II. _____

III. _____

IV. _____

V (GAF)

Previous Diagnoses: (check all that apply): ☐ Anxiety ☐ Reactive Attachment Disorder ☐ PTSD

☐ Conduct Disorder ☐ Personality Disorder ☐ Depressive Disorder ☐ ADHD/ADD ☐ ODD

☐ Bipolar Disorder ☐ Pervasive Developmental Disorder ☐ Autism Disorder ☐ Asperger Syndrome

☐ Mental Retardation ☐ Schizoaffective Disorder ☐ Other(s):

Medical Problems: _____

Current Medications (Dosages): _____

Social Supports: ☐Family ☐School ☐Friends ☐Local Mental Health Staff ☐Guardian/DSS
☐Spiritual ☐Other: _____ ☐None
Cultural, Spiritual, Religious Orientation / Information: _____
_____ ☐None

Most Recent IQ (FSIQ, Verbal Comprehension Index, Processing Speed, Working Memory, and Perceptual Reasoning Index)/Level of Functioning Assessments/Dates of Testing:

*Note:*** If Verbal Comprehension Index is below 75 or Full Scale is below 70, it would be unlikely the applicant would benefit from the program. A referral to the STARS program at Murdoch is recommended.****

WISC-IV Date _____ Considered Valid? ☐Yes ☐No

Verbal: _____ Perceptual _____ Memory _____ Processing Speed _____ Full Scale IQ _____

Educational History: Last School Attended: _____

Last Grade Completed: 6, 7, 8, 9, 10, 11, 12, GED ☐ Repeated Grades, explain: _____

Exceptional Resident Status: ☐None ☐SED ☐Other Health Impaired ☐Learning/Language Disabled

Attendance: ☐Good ☐Poor ☐None, Explain: _____

☐Suspensions: _____

☐Expulsions: _____

☐Homebound / In-Home Teaching: _____

Additional Pertinent Educational Information: _____

Current and Previous Legal Status: ☐N/A ☐Current or Pending Legal Charges ☐Past Charges

☐Current Probation _____to_____ ☐Juvenile ☐Adult

Court Counselor: _____

Phone/FAX #'s: _____ County: _____

Detention ☐No ☐Yes Dates: _____

Youth Academy ☐No ☐Yes Dates: _____

Adult Jail ☐No ☐Yes Dates: _____

Strengths

- ☐ Has residence to return to upon discharge
- ☐ Supportive family / friends
- ☐ History of cooperation with outpatient treatment
- ☐ History of successful employment
- ☐ Financial Resources
- ☐ Expresses need for help
- ☐ Other: _____

Deficits

- ☐ Possibly / cannot return to prior residence
- ☐ No or limited supportive family / friends
- ☐ History of treatment non-compliance
- ☐ Poor or no employment History
- ☐ Poor or no financial resources
- ☐ Limited or no insight into conditions
- ☐ Other: _____

Symptoms / Behavior Changes:

- | | | |
|---|---|--|
| <input type="checkbox"/> Suicidal | <input type="checkbox"/> Overdose | <input type="checkbox"/> Self-injurious behavior |
| <input type="checkbox"/> Homicidal | <input type="checkbox"/> Physical aggression | <input type="checkbox"/> Temper tantrums |
| <input type="checkbox"/> Conflict with family | <input type="checkbox"/> Physical threatening | <input type="checkbox"/> Verbal threatening |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Property destruction | <input type="checkbox"/> Running away |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Agitation | <input type="checkbox"/> Irritability / Anger |
| <input type="checkbox"/> Social withdrawal | <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Decreased energy |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Paranoia | <input type="checkbox"/> Poor judgment |
| <input type="checkbox"/> Decline in Self-care | <input type="checkbox"/> Delusions | <input type="checkbox"/> Disorganized thinking |
| <input type="checkbox"/> Anhedonia | <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Pressured speech |
| <input type="checkbox"/> Weight change | <input type="checkbox"/> Appetite Change | <input type="checkbox"/> Memory impairment |
| <input type="checkbox"/> Cognitive impairment | <input type="checkbox"/> Gang Involvement | <input type="checkbox"/> Hopelessness / Guilt |
| <input type="checkbox"/> Sexual acting out: <input type="checkbox"/> Promiscuity <input type="checkbox"/> Offending: Victims_____ | | |

Primary Symptoms/Behaviors (check all that apply)

	Yes	No	Unknown	If yes, describe
Psychotic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Assaultive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Suicidal or Self-Destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Runaway Tendencies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sexual Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Additional Information: _____

Substance Abuse History: ☐ Patient Denies ☐ None Known ☐ Not Applicable ☐ Yes
☐ Alcohol

Stimulants: ☐ Dexadrine ☐ Ritalin ☐ Methamphetamines ☐ Cocaine ☐ Powder ☐ Crack ☐ Cannabis

Designer Drugs: ☐ Ketamine ☐ Ecstasy ☐ GHB ☐ Rohypnol

Opioids: ☐ Heroin ☐ Morphine ☐ Oxycodone ☐ Methadone ☐ Darvocet ☐ Opium ☐ Codeine
☐ Other

Hallucinogens: ☐ LSD ☐ Mescaline ☐ PCP/Angel Dust ☐ Psilocybin Mushrooms ☐ Other:

Inhalants: ☐ Gasoline ☐ Amyl Nitrates ☐ Paint ☐ Other

Information _____

Concerns in Home and Community: (indicate area(s) of needs, problems, or barriers)

☐ Primary Support System ☐ Economic ☐ Educational ☐ Occupational ☐ Legal ☐ Health Care

Explain: _____

Behaviors or conditions that make continued placement in the home community difficult.

List and describe interventions/placements previously tried and which aspects were successful/unsuccessful (include out-patient treatment, residential, hospitalization, etc.)

If there are additional placements, please attach.

Treatment Intervention/Placement	Dates	Applicant Response

ECOLOGICAL INFORMATION

*****NOTE: EACH RESIDENT MUST HAVE A VISITING RESOURCE FOR MANDATORY, TWICE-MONTHLY VISITS IN THE COMMUNITY IN A SAFE AND SUPERVISED ENVIRONMENT FOR SUCCESSFUL REINTEGRATION INTO THE COMMUNITY. STEP DOWN PLACEMENTS MUST BE INDICATED AND APPROPRIATE.*****

Identification/Description of Visiting Resource: _____

Plans for transportation to and from Visiting Resource: _____

Discharge Plan - Whitaker PRTF prepares residents to live in less restrictive environments on discharge. However, the problems of our residents are more severe than most. They continue to need intense services (though not in a locked facility) after they leave Whitaker.

Anticipated Needs Upon Discharge: Can resident return to prior living arrangement?: ☐ Yes ☐ No

Refer to local Mental Health / Developmental Disability / Substance Abuse Services with following recommendations:

<input type="checkbox"/> Individual Therapy	<input type="checkbox"/> Community Support Services	<input type="checkbox"/> Developmental Disability Services	<input type="checkbox"/> Medicaid
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Group Home Placement	<input type="checkbox"/> Multi-systemic Therapy (MST)	<input type="checkbox"/> Social Security / SSI
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Legal Services	<input type="checkbox"/> Psychiatric Residential Treatment Facility	<input type="checkbox"/> Medication Financial Assistance
<input type="checkbox"/> Case Management	<input type="checkbox"/> Supportive Employment	<input type="checkbox"/> Diagnostic Assessment	<input type="checkbox"/> Day Treatment
<input type="checkbox"/> Intensive In-Home Psychiatric Services	<input type="checkbox"/> Partial Hospitalization	<input type="checkbox"/> Child & Adolescent Day Treatment	<input type="checkbox"/> Need Guardian
<input type="checkbox"/> Assertive Community Treatment Team (ACTT)	<input type="checkbox"/> Medication/Symptom Management	<input type="checkbox"/> Public School Education / Evaluation	<input type="checkbox"/> Self-Help Group / AA, etc.
<input type="checkbox"/> Mobile Crisis Management	<input type="checkbox"/> Outpatient Commitment	<input type="checkbox"/> Public Health/Home Health	<input type="checkbox"/> Speech, PT, OT Services
<input type="checkbox"/> Substance Abuse Treatment	<input type="checkbox"/> Leisure Activity	<input type="checkbox"/> 1:1 Mentor	<input type="checkbox"/> Weekly 1:1 Time with Parent / Guardian

Other Recommendations: _____

TREATMENT ISSUES

Why are you referring? _____

List questions that need to be answered for the child to be successfully maintained in the community? _____

What services will the LME provide while the applicant is in Placement? _____

Signature: _____
 Person Making Referral

Date: _____

Signature: _____

Date: _____

Additional Information (Please attach information behind this page)

For the referral packet to be placed on the waiting list, all starred items must be provided in the packet. The packet will remain on a prospective list until this information is provided. *NOTE: Developmentally disabled and/or mentally retarded residents should be referred to the STARS Program at Murdoch Center. (Phone Number: 919-575-1070)*

Psycho-educational Testing: (NOTE: To be considered, a psychological with IQ scores that are within 24 months of the referral is mandatory. The entire report must be sent, not just the scores)

- * _____ Psychosocial Assessments
- * _____ Psychological Testing Including IQ Testing (within the last 2 years)
- * _____ Admissions Assessment Psychiatric Hospitals or Mental Health Centers
- * _____ A detailed Life Chart or a thorough Developmental/Social History
- * _____ Discharge Summaries from Prior Treatment Facilities (if applicable)
- * _____ Achievement testing (most recent but within the last 3 years)
- * _____ School Transcripts (most recent)
- * _____ Report cards (most recent and previous report cards for the entire current school year)
- * _____ Standardized testing (End of Grade [EOG 5-8] and End of Course [EOC 9-12] tests, Computer skills, Reading/Math competencies)
- * _____ Exceptional Children's Forms to include **all DEC forms** (DEC 1-7 and a current IEP (DEC 4) that indicates SED, LD, OHI, other)* **Please note that if a child has been identified as an Exceptional Child (EC), legally s/he should have a current IEP.**
- * _____ Vision and Hearing Screenings (Recent)
- * _____ Current Physical and Immunization Records
- * _____ Referral packet information sheets.
- * _____ Copy of social security card
- * _____ Copy of birth certificate. (if available)
- * _____ Consent to Exchange Information Form
- _____ Older report cards from previous school years.
- _____ Older psychological testing.

- _____ Psychiatric Assessment (mandatory if available)
- _____ Personality Assessments (if available)
- _____ Discharge Summaries from Psychiatric Hospitalizations (if applicable)
- _____ Neurological Testing (if applicable)
- _____ Speech/Language Evaluation (if applicable is mandatory)
- _____ Most Recent LME Service Plan which includes: Goals, Strengths, and Weaknesses.
- _____ DSS Reports (if applicable)
- _____ Juvenile Court Reports (if applicable)
- _____ Staffing Notes from the Collaborative Meeting
- _____ Other _____
- _____ Other _____

**North Carolina Department of Health and Human Services
Division of MH/DD/SAS
Child and Family Services Section
SECURE CARE REFERRAL UPDATE SHEET**

***** (THIS SHEET IS NOT PART OF THE ADMISSIONS PACKET. IF THE CHILD HAS TO WAIT FOR A BED, IT SHOULD BE FILLED OUT AT LEAST BI-MONTHLY AND FAXED TO 919-575-7489 IN ORDER FOR THE CHILD TO REMAIN IN CONSIDERATION FOR ADMISSION)*****

Client's Name: _____ Date of Approval: _____

LME: _____ Date: _____

Check appropriate box for any new or additional information completed since the last update.

- | | |
|---|--|
| <input type="checkbox"/> IEP | <input type="checkbox"/> Psychological Evaluation |
| <input type="checkbox"/> DEC Forms | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Hospitalization |
| <input type="checkbox"/> Therapy | <input type="checkbox"/> Visiting Resource/Step Down |
| <input type="checkbox"/> Medication | <input type="checkbox"/> Other |

Please attach a copy of all new or additional information.

Describe any significant life events and/or changes to his/her living situation since the last update.

Describe any contact with the legal system; courts; and/or police since the last update?

Describe any aggression, physical violence towards others, and/or self-injurious behavior since the last update.

Outline changes in services received since last update.

Priority _____

Case Manager Signature

Date